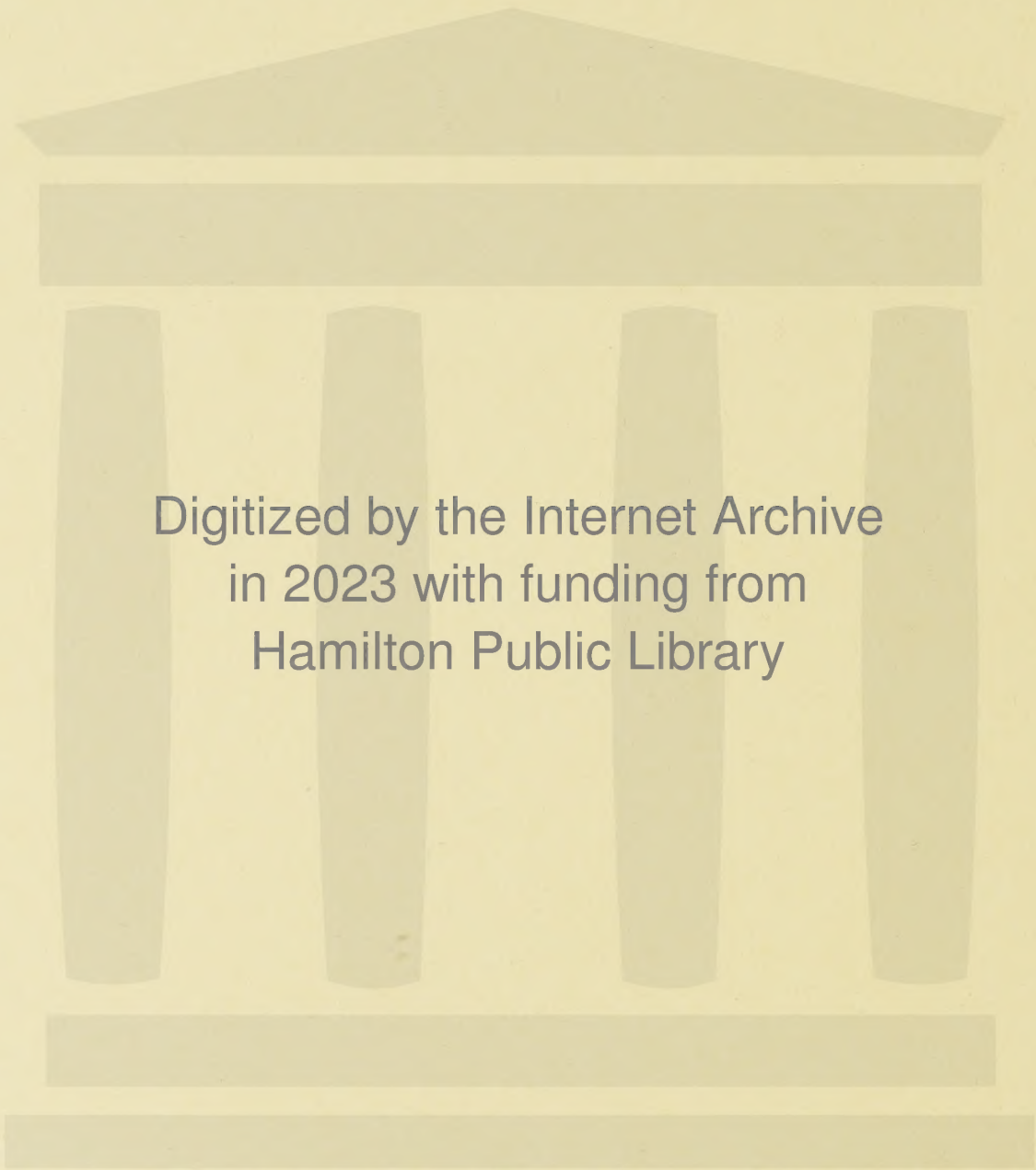
ANNUAL REPORT

Assessment and Placement Service of the Hamilton District Health Council

APS

1975



FOURTH ANNUAL REPORT
OF THE
ASSESSMENT AND PLACEMENT SERVICE
OF THE
HAMILTON DISTRICT HEALTH COUNCIL
1 JANUARY 1975 - 31 DECEMBER 1975

MANAGEMENT COMMITTEE

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Information Analyst	Mrs. D. Babiski[3]
Secretary	Mrs. K. Milne
Clerk/Stenographer	Miss J. McMahon

1. Resigned August 1975
2. Appointed October 1975
3. Appointed May 1975

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HISTORICAL BACKGROUND

The A.P.S. was established by the Hamilton District Health Council in I97I on the advice of the then newly formed Extended Care Committee. The project was funded in April of that year by the Ontario Ministry of Health and commenced operation in September I97I.

One of the concerns of the Health Council has been the promotion of optimal utilization of the services for the disabled and chronically ill. The Extended Care Committee was formed to study the needs of this group and the services available. The result of their discussions was the recommendation that a coordinating body be formed to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations of the appropriate programs or levels of care for the development of the individual's assets and potential.

The Health Council appointed a medical consultant and two members of the health professions to provide the coordinating evaluation function; a part time administrator and secretarial staff; and a data analyst to maintain statistics for the evaluation of the service's efficacy and the provision of an information base for future planning in the health needs of the disabled.

Assessment Form

Prior to commencement of operation an Assessment tool was developed to provide the necessary information for appropriate recommendation. Broadly, this information falls into three categories:

(a) demographic (age, sex, marital status, next of kin, education, employment and cultural background, present location and level of income)

(b) medical (diagnosis, prognosis, treatment, level of cognitive function, emotional status)

(c) functional capacity (degree of ability to walk, talk, see, hear, comprehend, dress, bathe, undertake personal care and household care).

The demographic and functional capacity data is provided by a social worker-nurse team for the hospitalized applicant and by the Public Health or Victorian Order Nurse for those applicants at home. The medical information is provided by the applicant's personal physician.

Recommendations

Recommendations are made on the basis of the information provided by the Health Care team with additional input as indicated and with an intimate knowledge of the available facilities and programs.

Recommendations include appropriate level of care, and/or programs of rehabilitation or recreation, and programs whereby the disabled person may be assisted toward a meaningful role in society.

Referral Process

Referrals are made by health professionals in the community or health care institutions and/or members of the community, and may be as simple as a telephone call asking for the process to be set in motion.

MEDICAL CONSULTANT'S REPORT

- J.R.D. Bayne, M.D., F.R.C.P. (C)., F.A.C.P. -

This report will discuss some of the characteristics of people referred to this service for long term planning either from the community or from an institution and will give some indication of future trends.

The Assessment and Placement Service (APS) has been in existence since 1971, and by December 1975 had received 9300 referrals. The aims and purposes have remained unchanged and are described elsewhere in this Report. The number of referals per year were 1482 in 1972, 2783 in 1973, 2618 in 1974 and 2472 in 1975[1]. The majority of people referred have been 60 years of age or more and constituted 84% of the total in 1972 and 88% of the total in 1975. The service is prepared to receive referrals for people of any age and with any mental or physical disability, but the preponderance of older people reflects the high prevalence of disabling disease in this age group and the inability of many of those so afflicted to continue in independent living. The challenge to organized health services will become greater during the next 25 years when the population of aged 65 or more will double.[2]

The 1971 Census[3] showed that while the population of Ontario was 7,703,000 the number of people aged 65 and more was 644,500, or 8.4%. At the same time the population of Wentworth county and Hamilton was 401,883 and the number age 65 or more was 35,890, or 8.8%. These numbers will have increased since then, and in accordance with Canadian statistical projections will reach 12% of the population by 2001.

Available to this population and its aged are approximately 800 physicians registered with the College of Physicians and Surgeons, 115 Home Nursing Personnel, 70 Public Health Nurses, 115 Homemakers,[4] a coordinated Home Care Program and a variety of other health and social community services such as Meals on Wheels, Teletouch and recreation programs. These numbers vary from month to month due to movement of health professionals and variation in requests for service. Institutionally based programs include emergency and acute hospital care, rehabilitation, chronic hospital care. These types of institutional care are listed and briefly described in this Report with information reprinted from a Ministry of Health Booklet. The costs of care in these various programs is related to the intensity and technological complexity of the services provided and the rapidity of movement of people through them, both of which elevate costs. An estimate of these costs can be gained from the rates that would have been charged in 1975 if each patient were paying for himself.* It is evident that institutional health care is expensive, and that even the less expensive programs continued over a prolonged period become financially onerous.

* See p. 18.

It is obviously important to ensure that each person is located in the type of care program where his needs can be met but where no more services are provided than he needs. Each person therefore must have his needs and potentials clearly identified and be helped to enter the appropriate program, and to remain in it only as long as (but also just as long as) he is significantly benefitting.

Physicians and other health professionals have the daily experience of assessing a patient's needs for acute or emergency care. Where they have less experience is in assessing the need for on-going supportive or restorative services. The A.P.S. exists precisely to help in identifying those needs and potentials and to help in gaining access to the appropriate programs. The process of referral and recommendation may be complex. The earlier after onset of a disability the person is assessed the more likely it is that potentials for improvement can be recognized and that time is available to arrange for services needed. However, the health status is often unstable at this time so frequent up-dating of information by telephone is necessary between the referring professionals and the A.P.S. Counsellor. In addition the person may not accept the recommendation at this stage and may refuse the suggested program. Recommendations are rejected most often by people who a) have a requirement for assistance with personal care, b) have no one to provide such care in the home, c) have no severe disabilities, and d) have been advised that long term residential care is indicated. More community support programs are needed if we are to help people stay at home and cope with their disabilities which many of them wish to do.

A.P.S. has waiting lists for every type of care except emergency and acute hospital care. If the demand for residential institutional care of the least intensive type could be diminished by more community support programs and if such institutional care was reserved for people needing skilled care and support to such a degree that they were unable to remain at home, then movement might occur right up through the system as people found vacancies at appropriate levels. At present the demand for more long stay institutional beds continues to be heard. It has been pointed out that Ontario already has placed a higher percentage of its aged in institutions than other countries which have greater geriatric populations. An alternative commonly suggested is that families should provide the care and support for those elderly unable to live independently.

It has been found from the data of previous years[1] and also for the year 1975 that approximately 1/3 of the people referred to A.P.S. are living alone and 1/4 with a spouse only. It would therefore devolve on their adult children or relatives to provide the needed care. Reliable studies[8] have shown that the great majority of elderly do have frequent contact with members of their families although living separately but to provide on-going physical care may require almost a constant or full time commitment from family members. However, the trend to the development of pre-school nurseries and kindergartens related to the increasing incidence of

of women seeking employment once their plans for childbearing are completed, suggests it is unlikely that the majority of the disabled elderly will be looked after by their adult children in the future. In addition, with increasing longevity, the adult children may themselves be over age 65 and in frail health.

Returning a disabled person to the community may appear to be an inexpensive alternative to institutional care, but of course if his care needs are the same then the requirements for someone to provide that care are the same. The difference is that in the private home the costs are disguised, and are born by the family instead of the community. If such costs are to be more equitably distributed then they must be shared by the community. This could be done by increasing community support services by trained and paid personnel. An alternative might be to pay family members for providing such care.

It was found in 1975 that 666 referrals were received for people living at home and that 453 placements were to private residences or boarding houses, often with the support of some community services. In other words, a considerable number of people were living outside an institution on referral, and a number were able to return or remain there. The importance of the problems or burden of responsibility this may impose can be gauged in part from the Tables: Impairment of Memory and Judgement. This shows that in the opinion of their physicians in only 20% of all referrals was memory considered to be normal and in only 13% was judgement normal. Brief periods of forgetfulness or confusion and disorientation was present in 42% whereas marked confusion, disorientation or no recall was present in 25%. In the remaining 13% of referrals this information was not provided to A.P.S. Judgement was considered adequate for personal safety or there was limited ability to be realistic in judgement in 50% of referrals, but judgement was grossly impaired or there was inability to make any judgement in 25%. In the remaining 12% of referrals this was not recorded.

The high frequency of impairment in memory and judgement is supported by the frequency with which physicians listed an organic brain disease among the diagnoses. An average of 2.8 diagnoses were listed on each referral and the ten most common are listed on page 16. It can be seen that 3 of the top 4 conditions are conditions that commonly are associated with impairments of memory and judgement. In Canada, up to now, few old people have been found frozen or severely neglected, but we must develop a new interest and greater support to prevent such incidents in the future if any significant numbers of elderly with health impairments are to be maintained in any degree of independent living.

The development of a coordinated program in Geriatrics such as is now occurring in the Hamilton-Wentworth district will go a long way to improving the assessment and treatment of the elderly and to assuring that everyone has access to quality care.

References

1. A.P.S. Annual Reports 1972 and 1973, and 1974.

2. Mary K. Rombout - Supplement to Hospitals and the Elderly Present & Future Trends. Long Range Planning Branch, Dept. N. at Health and Welfare Canada - July 1975.

3. 1971 Census, Statistics Canada.

4. Personal communication.

5. Types of Care, Ministry of Health of Ontario, publication # 75-2222 8/75.

6. Personal communication

7. Schwenger, C., Editorial, Canadian Journal of Public Health, p. 65, Nov. Dec. 1974.

8. Shanas et al, Old People in Three Industrial Societies, Atherton Press, New York, 1968.

ADMINISTRATOR'S REPORT

Joyce Caygill

This year the entire staff spent considerable time on the revision of our Referral Form. This new assessment instrument has a precoded format and incorporates many suggestions made by users of the form. The final draft was printed ready for use on January 1, 1976. Obviously, changes in one instrument necessitated changes in others associated with it. The results are, we believe, an aid to increased efficiency within the service.

Toward the end of 1975 an automatic follow-up procedure one month after placement was instituted which will be continued through 1976. Results will be included with the 1976 data. As of January 1, 1976 we will be coding and keypunching information on a weekly basis in order that we may supply up-to-date statistics for those involved in planning for future Health Care in this area. Requests for information regarding either 1976 or previous years' data are welcomed.

Questions have been posed in the past regarding the costs or savings involved in a referral to our Service. Unfortunately, a truly accurate answer could not be given without first determining the percentage of staff time involved in each of our three objectives:

a) promoting better assessment of the needs of persons with long term disabilities utilizing the personal physician and other health personnel closely associated with the patient

b) finding appropriate programs that could meet these needs and identifying whatever modifications or new approches might be required

c) providing a resource for the education of health personnel in the complex needs of the chronically ill and handicapped. (see page 16, A.P.S. Annual Report, 1972)

However, for those who wish to make their own calculations a list of accommodation/program fees appears on page 18.

It would seem reasonable to balance the cost/savings of the referral process with the costs of long term care in an active treatment hospital and/or continuing or chronic care institutions. It is also essential to remember that the provision of the most suitable type of care is less expensive than one which may provide more services than are necessary or can be used. Such inappropriate care is both costly to the taxpayer and a disadvantage to the recipient in terms of loss of independence and in underutilization of potential.

In 1975 patterns established in previous years were repeated. 2472 referrals were received compared with 2618 in 1974, and 2792 in 1973. Of the 2472 referrals in 1975, 2005

were completed, 467 were still awaiting placement on January 1, 1976.

Waiting Periods

The average number of persons awaiting placement at any time during the year was 420. Peak month was July with 570 awaiting placement, lowest was March with 357. This shows an increase over the highs and lows for previous years (1974: high September 373; low January 275).

Sample month: November 1975. Location of persons awaiting admission to a program were as follows:

In Acute treatment hospitals awaiting admission to:

Nursing Homes	65	
Chronic Hospitals	67	
Homes for the Aged	16	
Rehabilitation Units	15	
Support Services in Community	14	
	177	

At home awaiting admission to:

Nursing Homes	66	
Chronic Hospitals	25	
Homes for the Aged	58	
Rehabilitation Units	3	
Support Services in Community	68	
	220	
TOTAL		397

N.B. The remainder of the statistical information in this report refers to the 2005 cases which were both referred and placed in 1975.

Referrals

Referrals came from as far away as British Columbia, Montreal and Florida, U.S.A. (e.g. people taken ill on vacation and requiring long term care on their return). Placements have been made to areas within Ontario such as Peterborough, Kingston, Guelph, Simcoe and North Bay. Four persons were placed outside Ontario. Naturally, the majority of referrals and placements are within the Hamilton-Wentworth region and Burlington. (H-W.B.)

Of the 2005 referrals completed in 1975, 1063 came from active treatment hospitals in Hamilton and Burlington, 201 from other facilities in those areas, (e.g. Chronic hospital, Homes for the Aged etc.). 628 were referred directly from the community either by the family physician or other health care personnel, the family or friends. In addition, 71 persons were referred from active treatment hospitals and other facilities in communities outside Hamilton-Wentworth or Burlington, and 38 persons were referred directly from outside communities. (Incomplete data:4)

As in previous years, referrals of women consistently

outnumber those of men, 1187 females, 811 males (Incomplete data:7). 89.6% of females referred were in the age groups over 65. For men the percentage in the same age groups was only 65.8. Men are referred at an earlier age than women, 13.8% in the 55-64 decade compared with 6% in the same decade for women.

The percentage of widows referred over the age of 65 (71.1%) is considerably greater than widowers (25.9%). The percentage of over 65 females who are married (16.25%) is less than that for men (33.96%).

Our data shows that 1333 persons had some impairment of memory, 497 of which were severely impaired (Incomplete data: 258), and 1488 had some impairment of judgement, 494 of which were severely impaired (Incomplete data:258).

Placements

It is important to note that some people require more than one placement, e.g. Rehabilitation followed by Homes for the Aged. Therefore, of the 1519 placements made in 1975, 1286 were first placement, 208 second and 25 third placement. (In addition, we were able to place approximately 150 persons who were referred in 1974 but who were still awaiting accommodation in a program or facility on January 1, 1975). 839 placements were made to long term care facilities in the Hamilton-Wentworth and Burlington areas, while 414 were made to lodging house, or private residence, in the community. Sixty five placements were made to facilities outside the H-W.B. areas and 39 were placed in outside communities. One hundred and forty nine persons required admission to active treatment hospitals in H-W.B. and 9 required admission to active treatment hospitals in other areas. Four persons were placed outside Ontario (Total=1519). 216 persons refused placement, 301 died before placement, and 179 experienced a change in condition requiring rereferral, 23 were refused by facility/program.

N.B. It is our experience that many of the people who refuse placement do so because they are reluctant to surrend--er their independence. These people often approach us again within months, at which time there may be a change in condition necessitating a rereferral. Change in condition may be due to gradual deterioration, or a sudden change as with C.V.A., bone fracture, etc.

The data contained in this report has been compiled from information provided by various health care professionals for the purpose of determining the ongoing care needs of their patients.

The staff of A.P.S. join me in expressing gratitude to all providers of health care in this area for their continued support, assistance with assessments, cooperation in placement, and constructive criticism and advice.

LOCATION AT TIME OF REFERRAL

Joseph Brant	115	1062
Chedoke	74	
Henderson	323	
St. Joseph's	288	
Hamilton General	177	
M.U.M.C.	85	
*H-W.B. Community	628	
Other H-W.B. facilities	201	
Facilities other than H-W.B. areas	71	
Community other than H-W.B.	38	
Missing data	5	

*H-W.B. = Hamilton-Wentworth Region and Burlington

N = 2005

LOCATION OF PLACEMENT

Location	H-W.B.*	Outside H-W.B.	Outside Ontario	
Chronic Hospitals	252	7		
Nursing Homes	394	29		
Homes for the Aged	57	15		
Rehabilitation	126	---		
Ham. Psych. Hospital	10	---		
Homes for Spec. Care	---	4		
Other facilities	---	10		
Private residence	216	31		
Lodging house	81	5		
Day Care Centre	33	---		
Home Care Program	78	3		
Other	6	---		
Active Treatment Hospitals	149	9		
	---		4	
TOTALS	1402	113	4	1519

* H-W.B. = Hamilton-Wentworth Region and Burlington

CROSSTABULATION: DECADE OF BIRTH BY MARITAL STATUS FOR FEMALES

Age by Decade	MARITAL STATUS - FEMALES Single	M	D	Sep.	Widowed	Row Total
over 85	25	28	1	4	253	311
75-84	45	89	3	7	311	455
65-74	23	63	3	5	124	218
55-64	5	36	5	4	16	66
45-54	8	25	3	1	1	38
35-44	3	3	1	1	1	9
25-34	2	2	0	2	0	6
under 25	3	0	0	0	1	4
column totals	114	246	16	24	707	1107

N = 1187

Missing data = 80

CROSSTABULATION: DECADE OF BIRTH BY MARITAL STATUS FOR MALES

Age by Decade	MARITAL STATUS - MALES					Row Total
	Single	M	D	Sep.	Widowed	
over 85	9	48	1	5	63	126
75-84	27	124	6	9	86	252
65-74	29	81	12	20	44	186
55-64	13	55	5	17	13	103
45-54	9	27	8	6	2	49
35-44	5	5	2	1	1	14
25-34	5	1	0	1	0	7
under 25	7	0	0	0	0	7
column totals	104	338	34	59	209	744

N = 811

Missing data = 67

TEN MOST FREQUENTLY LISTED DIAGNOSES

Number of Diagnoses recorded 4921

Number of different Diagnoses recorded 326

Average number of Diagnoses per referral 2.8

Diagnosis	Absolute Frequency	Percentage of 4921
1 Generalized ischemic cerebro-vascular disease	329	6.7
2 Chronic ischemic heart disease	220	4.5
3 Senile and presenile dementia	219	4.5
4 Cerebral thrombosis	212	4.3
5 Symptomatic heart disease	199	4.0
6 Diabetes mellitus	184	3.7
7 Other cerebral paralysis	181	3.7
8 Essential benign hypertension	160	3.3
9 Fracture of neck of femur	137	2.8
10 Arteriosclerosis	135	2.7
	1976	40.2

MEMORY - recorded by Attending Physician on page 1, Assessment Form, Section B., 1975.

1 Normal	414
2 Brief periods of forgetfulness	432
3 Brief periods of confusion	404
4 Periods of marked confusion	377
5 No recall	120
Missing information	258
TOTAL	2005

JUDGEMENT

1 Normal	259
2 Adequate for personal safety	412
3 Limited	582
4 Gross impairment - unrealistic	255
5 Unable to make any judgement	239
Missing information	258
TOTAL	2005

COSTS OF INSTITUTIONAL AND HOME CARE

Daily accommodation rates for the UNINSURED patient for Standard ward level of care, December 31, 1975 (Hamilton)

Acute Care Hospital	115.00 to 141.00
Chronic Hospital	18.70 to 55.20
Nursing Home	19.00

Daily accommodation rates of the INSURED (OHIP) patient for Standard ward level of care, December 31, 1975 (Hamilton)

Acute Care Hospital	nil
Chronic Hospital	nil
*Nursing Home	6.15

*The Extended Care Benefit of OHIP provides a daily subsidy (12.85 in December 1975) to those who have been contributing members of OHIP, resident in the Province for one year and who require considerable nursing and personal care. Application form must be completed by a physician, decision regarding eligibility is based upon the 'points' system.

Average daily rate of Home Care Program is $8.08.

Cost to INSURED (OHIP) patient ..... nil.

OPERATING EXPENSES

	Dec 31,75	Dec 31,74
Salaries	100,397	87,494
Employee benefits	8,382	6,578
Office space & maintenance	*5,684	6,900
Advertising	369	1,714
Insurance	228	50
Business machines	1,545	1,973
Postage	497	851
Office supplies	4,886	2,939
Telephone	1,991	1,845
Travel	917	948
Data Processing	3,343	1,371
Staff Training	200	38
Other	64	28
	129,738	111,952

*this low figure is the result of use of temporary quarters prior to occupation of renovated premises

ASSESSMENT AND PLACEMENT SERVICE

DEFINITIONS:

Assessment	- the evaluation of the needs, capabilities, and assets of the applicants from the information supplied by physicians, nursing and social services and other health professionals.
Placement	- the identification and recommendation of the most suitable program(s) to meet the applicant's needs and develop his/her potential capabilities, and facilitation of the movement of the applicant to the site of the program(s) or the movement of the program(s) to the individual.
Referral Form	- the A.P.S. designed form used by the health professionals to provide demographic, medical, environmental and cultural background information on the applicant. Revised November 1974.

TYPES OF CARE

(extract: Patient Care Classification by Types of Care, Ontario Ministry of Health publication #75-2222 8/75, pp3-4)

TYPE I (RESIDENTIAL CARE)

Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

TYPE 2 (EXTENDED HEALTH CARE)

Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 3 (CHRONIC)

Care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 4 (SPECIAL REHABILITATIVE CARE)

Care required by a person with relatively stable disability such as congenital defect, post-traumatic deficits or the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

Type 5 (Acute)

Care required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown, or potentially serious condition; and/or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

TERMINOLOGY IN COMMON USE IN ONTARIO

Type I Care

Where provided

Homes for the Aged
Charitable institutions
Nursing homes
Foster homes
Group homes
Boarding homes
Homes for special care (residential care)
Children's institutions
Homes for unmarried mothers

Terminology

Domiciliary care
Ambulant care
Normal care
Residential care
"Intermediate care" in nursing homes
Community (social) support programs (mental):
- day care
- sheltered workshops
- supervised recreation

Type 2 Care

Where provided

Homes for the Aged
Nursing homes
Homes for special care (nursing homes)
Children's institutions

Terminology

Extended health care
Extended care
Homes for special care programs

Type 3 Care

Where provided

Chronic hospitals
Chronic care units in general hospitals
Nursing homes approved for chronic care
Geriatric units in psychiatric hospitals
Special facilities (schedule II) for mentally retarded with physical handicap
Children's institutions

Terminology

Chronic care
Care of the chronically ill
Chronic hospital care
Psycho-geriatric units (psychiatric hospitals)

Type 4 Care

Where provided

Regional rehabilitation centres

Terminology

Special rehabilitation care
Rehabilitation

Type 5 Care

Where provided

Public hospitals
Private hospitals
(G.H.P.U.) psychiatric units of general hospitals
Provincial psychiatric hospitals
Private psychiatric hospitals
Community psychiatric hospitals
Children's mental health centres

Terminology

Acute care
Active treatment
Psychiatric care (short and medium term)

NOTES

Data was accessed using the Statistical Package for the Social Sciences (SPSS) software package on the CDC 6400 of McMaster University.

Codes include:

Diagnosis	ICDA - 8 (International Classification of Diseases adapted for American use)
Location by facility	Ministry of Health Ministry Information System Division Data Development & Evaluation Branch Master Numbering System, 1975
Location by area	Ontario Postal Region Code
Physician	Medical Directory of the College of Physicians and Surgeons of Ontario

Mailing address for the Assessment & Placement Service:
Box 2085, Hamilton, Ontario

Telephone: 385-5361